770.992.6568
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SHENK DENTAL CARE

Judd W. Shenk, DMD

Please read through the following sections. The sections titled FINANCIAL POLICY and AUTHORIZATION both require the signature of the person responsible for the account. If you have any questions or concerns, please feel free to ask.

MINOR/CHILD CONSENT
I, being the parent or guardian of _____, do herby request and authorize the dental team to perform necessary dental services for my child, including but not limited to, x-rays and the administration of anesthetics which are deemed advisable by the doctor, whether I am present at the actual appointment when the treatment is rendered or not. I agree to be responsible for payment of all such services.

Signature of responsible party: _____ Date _____

FINANCIAL POLICY (Please read the following statement and initial/sign where indicated)
Patients are expected to pay in cash, check or by credit card on the day the service is rendered. I understand that I will be charged a $75 fee for failed appointments and appointments cancelled without 24 hours' notice.
Initial _____

For those patients of record who are covered by insurance, we will accept assignment of benefits. Most dental insurance plans do not cover 100% of the cost of treatment. Because of this and the extreme delay in receiving payment from the insurance company, we ask that you pay your deductible and co-payment on the day the service is rendered. We will estimate as closely as possible using the insurance information that we have, however THIS IS AN ESTIMATE. We will assist you in working with your insurance company, however, the ultimate responsibility lies with you. After 60 days, the balance will be due in full. Initial_____

I agree to be responsible for payment of all services rendered on my behalf or my dependent's, and I understand that payment is due at the time of treatment. I understand that a 1.5% finance charge will be added to my account for charges due over 60 days.

Signature: _____ Date _____

AUTHORIZATION
I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge.
I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.
I authorize my insurance company to pay the dentist or dental group all insurance benefits otherwise payable to me for services rendered.
I authorize the use of this signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.

Signature _____ Date _____